INDIVIDUAL SELF-INSURANCE GUARANTY FUND CLAIM FORM

DATE: _____

Person/Organization filing claim against the Fund:

Address: _____

_____

_____

Amount of Claim: $_____

Date of Accident_____

Workers' Compensation Court Claim Number:_____

Claimant: _____ Respondent: _____

Reason for Claim:

X _____

Signature

_____

Address City State Zip

_____

Telephone Number

☑ Check the appropriate box describing the filing party of this action:

☐ Claimant ☐ Med. Provider ☐ Attorney ☐ Other

NOTE: ATTACH COPIES OF ALL PLEADINGS FROM WORKERS' COMPENSATION COURT, BANKRUPTCY COURT AND DISTRICT COURT, IF APPLICABLE.